U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 10 July 2007

CASE NO.: 2005-BLA-00075

In the Matter of:

R.C.,
Claimant,

v.

PEABODY COAL CO.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES: Jared L. Bramwell, Esquire
For the Claimant

Scott A. White, Esquire
For the Employer

BEFORE: John M. Vittone
Chief Administrative Law Judge

DECISION AND ORDER AWARDING LIVING MINER'S BENEFITS

This proceeding arises from a claim for Benefits under the Black Lung Benefits Act, Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, at 30 U.S.C. §901 *et seq.* (Act), and the implementing regulations at 20 C.F.R. §§ 718 and 725 (2000).[1] The Black Lung Benefits Act is designed to compensate those miners who have acquired pneumoconiosis, commonly referred to as "black lung disease," while working in our Nation's coal mines. Those miners who have worked in or around mines and have inhaled coal mine dust over a period of

[1] Section 718 of Title 20 of the Code of Federal Regulations is applicable to the current claim, as it was filed after March 13, 1980.

time, may contract black lung disease. This disease may eventually render the miner totally disabled or contribute to his death.

A formal hearing was held on March 14, 2006, in Phoenix, Arizona, at which I admitted into the record Director's Exhibits (*DX*) 1-33; the Claimant's Exhibits (*CX*) 1, 5-8, and 10;[2] and Employer's Exhibits (*EX*) 1-38.[3] The decision in this matter is based upon testimony at the hearing (*Tr.*), documentary evidence admitted into the record at the hearing, and the post-hearing arguments of the parties.

PROCEDURAL HISTORY

The Claimant, R.C., filed his first claim for benefits on May 22, 1997. *DX 29.* The District Director, Office of Workers' Compensation Programs (District Director), denied benefits on September 26, 1997. *Id.* The District Director determined that the Claimant did not qualify for benefits because the evidence did not show that he had pneumoconiosis caused in part by coal mine work or that the Claimant was totally disabled by the disease. *Id.* The Claimant was instructed to either submit additional evidence or request a hearing if he disagreed with the District Director's Final Determination.[4] *Id.* The Claimant appealed on November 10, 1997.[5] *Id.* In a Final Memorandum of Informal Conference on July 17, 1998, the District Director confirmed the earlier denial on the grounds that the evidence failed to show that the Claimant had pneumoconiosis caused at least in part by coal mine work, or that he was totally disabled by the disease. *Id.*

The Claimant filed the current claim on October 18, 2000. *DX 1.* On July 6, 2001, the District Director determined that the Claimant was eligible for benefits and ordered the Employer to begin payments. *DX 25.* The Employer subsequently requested a formal hearing before the Office of Administrative Law Judges ("OALJ"). *DX 26.* The matter was allotted case number 2001-BLA-01073 and was assigned to Judge Karst. On May 20, 2005, Judge Karst remanded the matter to the District Director so that the Claimant's lay representative at the time could familiarize herself with the case.

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[2] Claimant's Exhibits 1-9 were admitted at the hearing. *Tr. 26.* The Claimant submitted Claimant's Exhibit 10 on April 18, 2006. By letter dated August 2, 2006, the Claimant informed the undersigned that Claimant's Exhibits 2, 3, 4, and 9 would not be submitted. As a result, the Claimant's Exhibits are numbered 1, 5, 6, 7, 8, and 10.

[3] The Employer submitted Employer's Exhibits 1-36 at the hearing and moved to submit Employer's Exhibits 37 and 38 post-hearing. *Tr. 31-32.* The motion was granted. *Tr. 33.*

[4] The letter stated the following about the appeals process: "Your claim can be scheduled for a formal hearing conducted by the Office of Administrative Law Judges of the United States Department of Labor. An informal conference may be scheduled prior to the hearing if it appears a conference would be helpful in resolving your claim." *DX 29.* The letter further instructed the Claimant that he had sixty (60) days to either submit additional evidence or request a hearing. *Id.*

[5] The Claimant's appeal letter stated, "I . . . do not agree with the decision that was made for me for Black Lung Benefits. I strongly agree that I am eligible. In the letter I got I was denied. Please take my case further more. Thank you for your cooperation." *DX 29.*

In October, 2005, the claim returned to the OALJ and was assigned the case number 2005-BLA-00075. A hearing was held before the undersigned on March 14, 2006, in Phoenix, Arizona.[6] The Employer's post-hearing brief was submitted on December 5, 2006, and the Claimant's on December 8, 2006.

ISSUES PRESENTED FOR ADJUDICATION

The issues listed as contested on the Form CM-1025 are as follows[7]:

1. Whether the claim was timely filed.
2. Whether the evidence establishes a material change in conditions per 20 C.F.R. § 725.309 (2000).
3. Whether the Employer is the Responsible Operator.
4. Whether the Claimant's most recent period of cumulative employment of not less than one year was with the named Responsible Operator.
5. Whether the Claimant is a miner.
6. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.
7. Whether the Claimant's pneumoconiosis arose out of coal mine employment.
8. Whether the Claimant is totally disabled.
9. Whether the Claimant's disability is due to pneumoconiosis.

DX 33.

FACTUAL BACKGROUND AND CLAIMANT AND FAMILY TESTIMONY AT THE HEARING

At the hearing, the Claimant testified via an interpreter that he was born in 1925 in Chilchinito, Arizona, where he currently resides. *Tr. 8 & 18.* He and his wife, who is now deceased, had eight children. *Tr. 8.* None of the children is considered dependent for augmentation purposes. *DX 1.* The Claimant testified that he began working in coal mines after

[6] As the miner last engaged in coal mine employment in the State of Arizona, appellate jurisdiction of this matter lies with the Ninth Circuit Court of Appeals. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989)(en banc).

[7] The Employer also listed the following issues:

1. Whether the regulations are Constitutional.
2. Whether the Responsible Operator is liable for medical care.
3. Whether the Responsible Operator is liable for payment of interest, fees, expenses, penalties, or other costs.
4. Whether payment of benefits is the responsibility of the Responsible Operator.

DX 33. The Employer neither pursued nor provided evidence to support these objections. Additionally, this court does not have the authority to address the validity of the Act or its implementing regulations such that the Employer's objections are noted for appeal purposes. As a result, these objections will not be addressed in this opinion.

several years at railroad and copper and uranium mine jobs. *Tr. 9-10.* The record indicates that the Claimant worked at the Employer's mine from October, 1973, to January, 1995. *DX 2 & 3.* He worked in both Utah and at the Employer's site in Kayenta, Arizona. *Tr. 21.* The Claimant testified that his last coal mine employment was in Kayenta. *Id.* The Claimant retired when he was seventy years old. *DX 1.*

The Claimant testified that he began working as a driller in the coal mines and later transferred to the tipple. *Tr. 10.* The Claimant's last job was as a tipple laborer. DX 2. The Claimant testified that he wore a mask while he worked but that "the dust was intense." *Tr. 11.* The Claimant testified that he often worked in the pit for six hours a day and then would do machine repair. *Id.* He worked Monday through Saturday and was covered in black dust at the end of each day. *Id.* The Claimant testified that his "mouth guard would be full of dust, black dust" at the end of each day. *Tr. 12.* The Claimant testified that much of his work in the slurry and the pit involved monitoring and repairing machines. *Id.* The Claimant also testified that he daily shoveled coal that was overflowing during the slurry process. *Tr. 13.* He also walked often and far between posts and described his work as "hard labor." *Tr. 14.*

The Claimant then testified to his physical health. He testified that he has never smoked and that he was in good health as recent as ten years ago but that his breathing is now "weak and it also affects [his] speech." *Tr. 14 & 15.* He finds it generally difficult to perform activities and he feels short of breath when he walks a city block. *Tr. 16.* He has difficulty walking around his house because he begins to wheeze. *DX 1.* The Claimant testified that he recently spent ten days in the hospital because his breathing was weak. *Tr. 16-17.* He testified that he sometimes coughs but that he does not have mucous build-up in his chest. *Tr. 17.* When asked if he thought he could perform the job that he last performed at the coal mine, the Claimant stated "[n]o, it's impossible" because of his difficulty breathing. *Tr. 17-18.*

The Claimant testified that he has never been told that he has tuberculosis and has never been treated for the disease. *Tr. 14-16.* The Claimant recalled being tested for the disease when he was a young boy but stated that he has not been tested since. *Tr. 15.* The Claimant's daughter-in-law, who is responsible for taking the Claimant to the doctor when he is ill, testified that the Claimant was tested for tuberculosis in 1995 but the results were negative. *Tr. 25.* The Claimant's daughter-in-law then testified that he had a positive PPD test and was given a sputum test for tuberculosis in 1997 but the tuberculosis was determined to be inactive. *Tr. 26 & 29.* The Claimant was given medication for six months to treat the tuberculosis. *Tr. 26.*

The Claimant's daughter-in-law testified that she normally takes the Claimant to clinics in Chilchinito and Kayenta but that he was hospitalized in Tuba City twice in 2005. *Tr. 27.* The Claimant's daughter-in-law testified that the Claimant was put on three different kinds of medication after his February, 2005, hospital stay, but was close to completing all of them at the time of the hearing. *Tr. 30.* She testified that the Claimant was on oxygen twenty-four hours per day from February to July of 2005, but he got tired of using it and quit. *Tr. 28.* The Claimant's daughter-in-law testified that the Claimant was very active ten years ago – hauling wood and coal for heat and working in the yard – but cannot be physically active today. *Tr. 30.*

DISCUSSION

TIMELINESS AND MULTIPLE CLAIMS ISSUES

The Employer raised the issues of whether the claim was timely filed and whether the Claimant established a material change of condition since the denial of his 1997 claim. However, close examination of the record reveals that the District Director did not properly act on the Claimant's timely hearing request in the original 1997 claim and as a result, the claim remains open.

Under the Act, if an employer or claimant is dissatisfied with the District Director's proposed decision and order, a request for a formal hearing may be made. 20 C.F.R. § 725.419(a) (2000). If the request is timely filed, then the District Director will transmit the file to the Office of Administrative Law Judges with a list of parties on the Form CM-1025a and contested issues on a Form CM-1025. 20 C.F.R. §725.421 (2000). Given the informal nature of the black lung claims process, considerable latitude is afforded claimants in construing hearing requests. Specifically, almost any informal communication submitted to the District Director at any point during the pendency of the claim at that level may be considered a hearing request. In *Plesh v. Director, OWCP*, 71 F.3d 103 (3d Cir. 1995), the Third Circuit held that a letter, wherein the miner stated, "I am appealing this as of now," constituted a formal hearing request thus, triggering the District Director's duty to refer all contested issues to the Office of Administrative Law Judges for resolution.

Here, the District Director denied the Claimant's 1997 claim in its September 26, 1997, letter. The Claimant was instructed to either submit additional evidence or request a hearing on his claim within sixty (60) days of the determination. The Claimant timely requested a hearing by stating that he "[did] not agree with the decision" and by asking that the District Director "[p]lease take my case further more." *DX 29.* Instead of forwarding the claim to the OALJ for a formal hearing, the District Director held an informal conference and again denied benefits. The District Director stated in her cover letter that the Claimant would need to make a second request for a formal hearing before his case would be submitted to the OALJ. *Id.*

According to *Plesh*, the Claimant's November 7, 1997, letter effectively triggered the District Director's obligation to forward the claim to the OALJ for a formal hearing. The Informal Conference and subsequent decision by the District Director did not terminate the District Director's obligation to forward the matter to the OALJ. As a result, I find that the Claimant's 1997 claim remains open and will be adjudicated according to the regulations that were in effect when the claim was filed. Because the 1997 claim remains open, the Employer's objections on the basis of timeliness and a material change in condition are no longer relevant.

RESPONSIBLE OPERATOR/MOST RECENT PERIOD OF CUMULATIVE EMPLOYMENT ISSUES

Liability for payment of benefits to eligible miners and their survivors rests with the responsible operator. The threshold requirement for identification of the responsible operator is

determining whether an "operator" is involved. Subsection 725.491(a), defines "operator" as the following:

> [A]ny owner, lessee or other person who operates, controls, or supervises a coal mine or any independent contractor performing services or construction at such mine..., [c]ertain other employers, including those engaged in coal mine construction, maintenance and transportation, shall also be considered to be operators for purposes of this part. An independent contractor or self-employed miner, construction worker, coal preparation worker, or transportation worker may also be considered a coal mine operator for purposes of this part.

20 C.F.R. § 725.491(a) (2000).

Liability is assessed against the most recent operator which meets the requirements at 20 C.F.R. §§ 725.492 and 725.493 (2000). An administrative law judge is required to go back up the chain of operators for which the claimant worked until the most recent operator, which meets the regulatory requirements and has the financial ability to pay, is identified. *See Cole v. East Kentucky Collieries*, 20 B.L.R. 1-51 (1996); *Director, OWCP v. Trace Fork Coal Co. [Matney]*, 67 F.3d 503 (4th Cir. 1995), *rev'g in part sub nom., Matney v. Trace Fork Coal Co.*, 17 B.L.R. 1-145 (1993).

The Claimant indicated in his application for benefits that he worked as a miner for the Employer from October, 1973, to January, 1995**.** *DX 2.* A July 1, 1997, letter from the Employer's human resources department verified this. *DX 3.* There is no evidence in the record to indicate that the Claimant did not regularly work for the Employer from 1973 to 1995 or that the Claimant worked elsewhere after he retired from working at the Employer's coal mines. Upon review of the employment records submitted and the testimony of the Claimant, I find that the Employer is properly designated as the responsible operator.

CLAIMANT AS MINER

The purpose of the Act is to provide benefits, in cooperation with the states, to miners who are totally disabled due to coal workers' pneumoconiosis. 30 U.S.C. § 901(a). Thus, a prerequisite to establishing entitlement to benefits is proving that the claim is on behalf of a coal miner or a survivor of a coal miner. Prior to the 1977 amendments, the definition of "coal miner" did not include "outside men" – those working at the tipple and in construction and transport at the mine. The 1977 amendments specifically extended coverage to such individuals when they work in conditions substantially similar to those in underground coal mines. The regulation at § 725.101(a)(19) provides:

> Miner or coal miner means any individual who works or has worked in or around a coal mine or coal preparation facility in the extraction or preparation of coal. The term also includes an individual who works or has worked in coal mine construction or transportation in or around a coal mine, to the extent such

individual was exposed to coal mine dust as a result of such employment (see §725.202).

20 C.F.R. § 725.101(a)(19). The regulations go further to state that there "shall be a rebuttable presumption that any person working in or around a coal mine or coal preparation facility is a miner." *20 C.F.R. § 725.202(a).*

The Claimant indicated in his testimony that he worked around the coal mines at the tipple and was exposed to coal dust on a daily basis. The Employer's human resources department verified this in its July 1, 1997, letter which states, "[w]hile in the employ of [Employer], [the Claimant] performed the duties of a Tipple Attendant at our Black Mesa Mine facility." *DX 3.* A tipple worker qualifies as a miner under the Act. Therefore, the Claimant is a miner for the purposes of claiming benefits under the Act.

LIVING MINER'S CLAIM FOR BLACK LUNG BENEFITS

The Claimant's claim for benefits must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. To prevail in a living miner's claim for Black Lung Benefits, the Claimant bears the burden of establishing each of the following elements by a preponderance of the evidence: (1) he suffers from pneumoconiosis; (2) arising out of coal mine employment; (3) he is totally disabled; and (4) his total disability is caused by pneumoconiosis. 20 C.F.R. § 718 (2005); *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986)(en banc); *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65 (1986)(en banc).

I. Existence of Pneumoconiosis and Its Etiology

Under the amended regulations, "pneumoconiosis" is defined to include both clinical and legal pneumoconiosis:

> (a) For the purpose of the Act, "pneumoconiosis" means "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> > (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. The definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (2005). Moreover, the regulations at 20 C.F.R. § 718.203(b) (2005) provide that, if a miner suffers from pneumoconiosis and has engaged in coal mine employment for ten years or more, as in this case, there is a rebuttable presumption that the pneumoconiosis arose out of such employment.

The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. § 718.202(a) (2005).

A. Chest X-Ray Evidence

A chest x-ray may indicate the presence or absence of pneumoconiosis as well as its etiology. The minimum interpretation that qualifies as positive for presence of pneumoconiosis under 20 C.F.R. § 718.102(b) (2005) is 1/0. If a chest x-ray is positive for the existence of pneumoconiosis, then the x-ray report should indicate the size, type, and quantity of opacities in the lungs. Larger and/or more plentiful opacities indicate that the disease is at a more advanced stage. Chest x-ray evidence is not utilized to determine whether the miner is totally disabled unless complicated pneumoconiosis is indicated. Complicated pneumoconiosis means that the miner has at least one opacity in his lungs that is one centimeter in diameter, which would be classified as category A, B, or C. When complicated pneumoconiosis is present, the regulatory provisions at 20 C.F.R. § 718.304 (2005) provide an irrebuttable presumption of total disability and/or death due to the disease.

When weighing chest x-ray evidence, the provisions at 20 C.F.R. § 718.202(a)(1) (2005) require that "where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays."[8] In this vein, the Board has held that it is proper to accord greater weight to the

[8] A"B-reader" is a physician, but not necessarily a radiologist, who successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and

interpretation of a B-reader or Board-certified radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and Board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). The following chest roentgenogram evidence is in the record:

Ex. #	***Physician/ Radiological Qualifications***	***Date of X-Ray***	***Date of Reading***	***Film Quality***	***Interpretation***
EX 8 at 202	Benton/ Qualifications Unknown	6/12/62	Unknown	Readable	- Healthy chest
EX 8 at 201	G. Wood/ Qualifications Unknown	11/13/67	11/13/67	Readable	- Heart is not unusual
EX 8 at 201	J. Vosskuhler/ Qualifications Unknown	12/29/67	Unknown	Readable	- Healthy chest
EX 8 at 200	J. Vosskuhler/ Qualifications Unknown	9/29/70	9/29/70	Readable	- Healthy chest, small calcification at right hilum
EX 8 at 200	J. Vosskuhler/ Qualifications Unknown	10/16/72	10/16/72	Readable	- Very minimal ill-defined density in left upper lung field
EX 8 at 199	J. Vosskuhler/ Qualifications Unknown	3/9/76	Unknown	Readable	- Very minimal diffuse scarring is seen in the upper lung fields - Small patch of infiltrate . . . might be a small patch of active disease
EX 12 at 33	Clark/ Qualifications Unknown	4/25/80	Unknown	Readable	- Scarring both upper lobes
EX 8 at 199	Unknown (Kayenta PHS medical records)	8/14/81	Unknown	Readable	- Diffuse hazy nodular lung disease more suggestive of pneumoconiosis than active tuberculosis
EX 8 at 198	J. Wood, Jr./ Qualifications Unknown	4/20/84	4/23/84	Readable	- Nothing to suggest an acute process - Opinion: probable silicosis
EX 20 at 13	David James/ B-Reader	10/6/93	10/7/93	1	- Parenchymal abnormalities consistent with pneumoconiosis: 1. Small opacities: 2/1 2. Large opacities: A - Other abnormalities: ho

Health (ALOSH). A designation of "Board-certified" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association.

EX 20 at 14	David Coultas/ B-Reader	10/6/93	11/13/93	2 Rotated	- Parenchymal abnormalities consistent with pneumoconiosis: 1. Small opacities: 2/2 2. Large opacities: B - Other abnormalities: ax, ca
EX 25	Lawrence Repsher/ B-Reader	10/6/93	5/5/04	1	- No parenchymal or pleural abnormalities consistent with pneumoconiosis - Other abnormalities: tb - Comments: conglomerate TB, probably inactive
EX 8 at 192	Unknown (Kayenta PHS medical records)	4/27/95	4/28/95	Readable	- Chronic interstitial lung changes - Cardiac silhouette is normal - Impression: most likely . . . active TB
DX 8	David James/ B-Reader	4/27/95	7/26/00	1	- Parenchymal abnormalities consistent with pneumoconiosis: 1. Small opacities:1/2 2. Large opacities: A - Other abnormalities: ax - Comments: blunted right CPA; right hilium calcification
EX 25	Lawrence Repsher/ B-Reader	4/27/95	5/5/04	1	- No parenchymal or pleural abnormalities consistent with pneumoconiosis - Other abnormalities: tb - Comments: Conglomerate TB, probably inactive
EX 29	Paul Wheeler/ Board-Certified Radiologist, B-Reader	4/27/95	1/31/06	2 Light	- Parenchymal abnormalities consistent with pneumoconiosis (with question mark next to "yes" box): 1. Small opacities: 0/1 2. Large opacities: O (question mark, line to A, and handwritten "depends on exposure") - Other abnormalities: dl, tb (with question mark next to it) - Comments: Oval 5 cm mass . . . small ill defined mass . . . compatible with conglomerate TB or histoplasmosis, possibly with coal workers' pneumoconiosis
DX 29	Cole/ Board-Certified Radiologist, B-Reader	6/17/97	7/1/97	2 Over-exposed	- No parenchymal or pleural abnormalities consistent with pneumoconiosis - Other abnormalities: tb - Comments: This may be tuberculosis rather than coal worker's pneumoconiosis
DX 24	Lawrence Repsher/ B-Reader	6/17/97	6/12/01	Unread-able (too dark)	- No comments
EX 2	Joseph Renn/ B-Reader	6/17/97	8/29/01	2	- No parenchymal or pleural abnormalities consistent with pneumoconiosis - Other abnormalities: tb

DX 29	Lawrence Repsher/ B-Reader	1/19/98	1/19/98	1	- No parenchymal or pleural abnormalities consistent with pneumoconiosis - Other abnormalities: tb - Comments: extensive scars of probable inactive TB
EX 25	Lawrence Repsher/ B-Reader	1/19/98	5/5/04	1	- No parenchymal or pleural abnormalities consistent with pneumoconiosis - Other abnormalities: tb - Comments: Conglomerate TB, probably inactive
EX 29	Paul Wheeler/ Board-Certified Radiologist, B-Reader	1/19/98	1/31/06	2 Copies	- Parenchymal abnormalities consistent with pneumoconiosis (question mark next to the "Yes" box): 1. Small opacities: 0/1 2. Large opacities: O and A marked on form with question mark and "depends on exposure and protection" - Other abnormalities: cg, tb (both with question marks next to them) - Comments: ill defined 5 cm mass . . . and subtle mass . . . compatible with conglomerate granulomatous disease more likely than large opacities of coal workers pneumoconiosis
EX 8 at 192	Edgar Cordivin/ Qualifications Unknown	11/6/98	Unknown	Readable	- Bilateral pulmonary scarring, no acute infiltrate or pleural effusion, heart is normal - Conclusion: Stable chest
EX 29	Paul Wheeler/ Board-Certified Radiologist, B-Reader	11/6/98 - AP	1/31/06	2 Hypo-inflation	- Parenchymal abnormalities consistent with pneumoconiosis (question mark next to the "Yes" box): 1. Small opacities: 0/1 2. Large opacities: O and A marked on form with "depends on *illegible* and dust exposure" - Other abnormalities: tb - Comments: ill defined 5 cm mass . . . compatible with conglomerate granulomatous disease, TB or histoplasmosis, more likely than large opacities of coal workers pneumoconiosis
EX 29	Paul Wheeler/ Board-Certified Radiologist, B-Reader	11/6/98 – LAT	1/31/06	2 Improper Position, Hypo-inflation	- Parenchymal abnormalities consistent with pneumoconiosis (question mark next to the "Yes" box): 1. Small opacities: 0/1 2. Large opacities: O and A marked with question mark - Other abnormalities: tb - Comments: ill defined 5 cm mass . . . compatible with conglomerate granulomatous disease, TB or histoplasmosis, more likely than large opacities of coal workers

					pneumoconiosis
EX 8 at 191	John Vosskuhler/ Qualifications Unknown	4/19/00	4/21/00	Readable	- Heart size is normal - Opinion: Moderate scarring . . . nothing to suggest reactivation
DX 9	David James/ B-Reader	4/19/00	7/26/00	2 Over-exposed	- Parenchymal abnormalities consistent with pneumoconiosis: 1. Small opacities: 1/1 2. Large opacities: A - Other abnormalities: dl
EX 25	Lawrence Repsher/ B-Reader	4/19/00	5/5/04	Readable	- No parenchymal or pleural abnormalities consistent with pneumoconiosis - Other abnormalities: tb - Comments: Conglomerate TB, probably inactive
EX 29	Paul Wheeler/ Board-Certified Radiologist, B-Reader	4/19/00	1/31/06	2 Improper Position	- Parenchymal abnormalities consistent with pneumoconiosis: 1. Small opacities: 0/1 2. Large opacities: O and A with question mark under both - Other abnormalities: tb (with question mark next to it) - Comments: oval 5 cm mass . . . and small ill defined mass . . . compatible with conglomerate TB or histoplasmosis, possibly with coal workers' pneumoconiosis
DX 10	David James/ B-Reader	11/30/00	11/30/00	2 Over-exposed	- Parenchymal abnormalities consistent with pneumoconiosis: 1. Small opacities: 1/1 2. Large opacities: A - Other abnormalities: None
DX 11	Leslie Preger/ Board-Certified Radiologist, B-Reader	11/30/00	3/2/01	1	- Parenchymal abnormalities consistent with pneumoconiosis: 1. Small opacities: 2/3 2. Large opacities: B - Other abnormalities: ax, es
DX 24	Lawrence Repsher/ B-Reader	11/30/00	6/12/01	2 Bilateral Scapulae	- No parenchymal or pleural abnormalities consistent with pneumoconiosis - Other abnormalities: tb - Comments: Bilateral upper zone healed tuberculosis
EX 2	Joseph Renn/ B-Reader	11/30/00	8/29/01	2 Left Scapula	- No parenchymal or pleural abnormalities consistent with pneumoconiosis - Other abnormalities: tb
CX 1	Thomas Miller/ Board Certified Radiologist, B-Reader	11/30/00	2/10/06	2 Bilateral scapula overlay	- Parenchymal abnormalities consistent with pneumoconiosis: 1. Small opacities: 2/2 2. Large opacities: B - Other abnormalities: ax, id - Comments: multiple bilateral small

					round opacities . . . 3/4 cm large opacity in the left upper lung and a 1.5 x 2 cm right suprahilar large opacity . . . coalescence of small pneumoconiotic opacities
EX 27	John Rizzi/ Qualifications Unknown	5/21/01	5/22/01	Readable	- Compared to 1/19/98 x-ray study - Extensive interstitial disease only slightly increased since earlier exam
EX 29	Paul Wheeler/ Board-Certified Radiologist, B-Reader	5/21/01	1/31/06	2 Improper Position	- Parenchymal abnormalities consistent with pneumoconiosis (question mark next to the "Yes" box): 1. Small opacities: 0/1 2. Large opacities: O and A marked with question mark underneath - Other abnormalities: cg, dl, tb - Comments: ill defined 5 cm mass . . . compatible with conglomerate granulomatous disease, more likely than large opacities of coal workers pneumoconiosis
EX 8 at 190	Sumathi Venkatappan/ Qualifications Unknown	8/2/01	8/3/01	Readable	- Comparison to 4/19/00 study - Cardiac and mediastinal silhouette is unremarkable - Increased interstitial markings . . . compatible with scarring - Impression: Chronic changes
EX 29	Paul Wheeler/ Board-Certified Radiologist, B-Reader	8/2/01	1/31/06	2 Artifacts, Improper Position	- Parenchymal abnormalities consistent with pneumoconiosis (question mark next to the "Yes" box): 1. Small opacities: 0/1 2. Large opacities: O and A marked with question mark underneath - Other abnormalities: dl, tb - Comments: compatible with granulomatous disease more likely than coal workers' pneumoconiosis
EX 8 at 189	Edgar Cordivin/ Qualifications Unknown	8/13/01	8/15/01	Readable	- Comparison to 4/19/00 study - Scarring in both upper lobes - Mild cardiomegaly - Conclusion: Stable chest
EX 29	Paul Wheeler/ Board-Certified Radiologist, B-Reader	8/13/01	1/31/06	2 Improper position, Hypo-inflation	- Parenchymal abnormalities consistent with pneumoconiosis (question mark next to the "Yes" box): 1. Small opacities: 0/1 2. Large opacities: O and A marked with question mark and "depends on exposure" - Other abnormalities: dl, tb - Comments: 4 cm mass . . . and 3 cm mass compatible with conglomerate granulomatous disease, TB or histoplasmosis, more likely than large opacities of coal workers pneumoconiosis

EX 8 at 189	Bruce Mazat/ Qualifications Unknown	3/23/02	4/1/02	Readable	- Comparison to 8/13/01 study - Infiltrates appear in the left upper lobe on a chronic basis and in the right upper lobe as a new finding - Changes present should be considered active tuberculosis until disproven
EX 29	Paul Wheeler/ Board-Certified Radiologist, B-Reader	3/23/02	1/31/06	2 Improper position, Hypo-inflation	- Parenchymal abnormalities consistent with pneumoconiosis (question mark next to the "Yes" box): 1. Small opacities: 0/1 2. Large opacities: O and A marked with question mark underneath - Other abnormalities: ca, dl, tb (with question mark next to it) - Comments: 3 cm mass . . . compatible with conglomerate more likely than large opacity of coal workers pneumoconiosis . . . mass in upper right hilum . . . may now be cancer
EX 29	Paul Wheeler/ Board-Certified Radiologist, B-Reader	4/15/02	1/31/06	2 Light	- Parenchymal abnormalities consistent with pneumoconiosis (question mark next to the "Yes" box): 1. Small opacities: 0/1 2. Large opacities: O and A marked with question mark and "depends on exposure and *illegible*" - Other abnormalities: dl, pi, tb (with question mark next to it) - Comments: mass . . . and small mass. . . compatible with conglomerate TB or histoplasmosis, more likely than large opacities of coal workers pneumoconiosis
EX 9 at 21	Edgar T. Clark/ Qualifications Unknown	8/2/02	8/3/02	Readable	- Parenchymal opacity in the left upper lobe . . . suggesting chronic granulomatous disease such as would occur with scarring from old tuberculosis - Active process cannot be excluded - Impression: Pulmonary parenchymal opacities which are probably chronic
EX 25	Lawrence Repsher/ B-Reader	8/2/02	5/5/04	2 Dark	- No parenchymal or pleural abnormalities consistent with pneumoconiosis - Other abnormalities: tb - Comments: Conglomerate TB, probably inactive
EX 29	Paul Wheeler/ Board-Certified Radiologist, B-Reader	8/2/02	1/31/06	2 Artifacts, Improper position	- Parenchymal abnormalities consistent with pneumoconiosis (question mark next to the "Yes" box): 1. Small opacities: 0/1 2. Large opacities: O and A, marked with question mark and "depends on exposure" - Other abnormalities: dl, tb (with question mark next to it) - Comments: ill defined mass . . .

					compatible with conglomerate granulomatous disease, TB or histoplasmosis, more likely than large opacities of coal workers pneumoconiosis
EX 36	Lawrence Repsher/ B-Reader	2/6/05	2/21/06	2 Under-exposed	- No parenchymal or pleural abnormalities consistent with pneumoconiosis - Other abnormalities: co, id, tb - Comments: infiltrate and nodule or nodular lesion; bilateral fibronodular disease; most compatible with far advanced healed TB
EX 36	Lawrence Repsher/ B-Reader	2/9/05	2/21/06	2 Under-exposed	- No parenchymal or pleural abnormalities consistent with pneumoconiosis - Other abnormalities: co, id, tb - Comments: parenchymal abnormalities include infiltrate and nodule or nodular lesion; bilateral fibronodular disease; most compatible with far advanced healed TB; no evidence of coal workers' pneumoconiosis
CX 10	Edgar Cordivin/ Qualifications Unknown	2/28/06	Unknown	Readable	- Comments: extensive scarring in both upper lobes consistent with old granulomatous disease - Impression: Extensive pulmonary scarring

Based on the foregoing, the Claimant has established that he suffers from pneumoconiosis. The x-ray studies dating from June 12, 1962, through April 20, 1984, are of little probative value because they are interpreted by physicians whose qualifications are unknown and do not address the presence or absence of coal workers' pneumoconiosis in compliance with 20 C.F.R. § 718.202(a)(1). They do, however, indicate that the condition of the Claimant's lungs worsened over time. Additionally, the final x-ray, taken on February 28, 2006, is of little probative value because the reader's qualifications are unknown and it was not classified in accordance with 20 C.F.R. § 718.202(a)(1). Consequently, my evaluation of the x-ray evidence will focus on the remaining thirty-nine interpretations of fifteen x-ray studies.

The October 6, 1993, x-ray was interpreted by three B-Readers. Drs. James and Coultas each determined that there were small and large opacities consistent with simple and complicated pneumoconiosis – Dr. James observed category 2/1 small opacities and category A large opacities while Dr. Coultas observed category 2/2 small opacities and category B large opacities. On the other hand, Dr. Repsher, also a B-Reader, did not diagnose the presence of complicated or simple pneumoconiosis. The positive interpretations by the two B-Readers who found similarly-sized opacities are more persuasive than Dr. Repsher's negative interpretation. As a result, the October 6, 1993, x-ray study supports a finding of both simple and complicated pneumoconiosis.

The next x-ray study was taken on April 27, 1995, and was interpreted by four physicians. The reading from Kayenta PHS holds little persuasive value because there is no

information about the physician who interpreted the film. One B-Reader, Dr. James, observed both small and category A large opacities consistent with pneumoconiosis. Dr. Repsher, also a B-Reader, determined that there were no abnormalities consistent with pneumoconiosis. The final interpretation, by the dually-qualified Dr. Wheeler, suggests that there are possible category A large opacities, but he qualifies the interpretation by saying that it depends on the Claimant's exposure to coal dust. On balance, this study does not support the absence of simple or complicated pneumoconiosis. Specifically, Dr. Repsher's negative interpretation is outweighed by the positive findings of Dr. James. Dr. Wheeler's observations are not inconsistent with the conclusions of Dr. James.

The next x-ray study, taken on June 17, 1997, was interpreted by three physicians. Dr. Repsher determined that the film was unreadable. Dr. Cole, a dually-qualified physician, and Dr. Renn, a B-Reader, each determined that the Claimant had no parenchymal or pleural abnormalities consistent with pneumoconiosis. As a result, the June 17, 1997, x-ray study does not support the conclusion that the Claimant suffered from either simple or complicated pneumoconiosis.

The January 19, 1998, x-ray study was interpreted three times by two physicians. While Dr. Repsher found no parenchymal or pleural abnormalities consistent with pneumoconiosis, Dr. Wheeler diagnosed category 0/1 simple pneumoconiosis as well as possible category A pneumoconiosis depending on "exposure and protection." Looking at the series of contemporaneous studies that pre- and post-date this study, as well as the superior radiological qualifications of Dr. Wheeler, it is evident that there are opacities and masses in the Claimant's lungs. Dr. Wheeler's more probative interpretation of the January 19, 1998, study is not inconsistent with a finding of complicated pneumoconiosis, although he diagnosed category 0/1 simple pneumoconiosis.

The November 6, 1998, x-ray study was interpreted three times by two physicians. Dr. Cordivin's interpretation is of little probative value because his qualifications are unknown and he does not address the presence or absence of pneumoconiosis. Dr. Wheeler reviewed two x-rays taken that day and again provided a noncommittal interpretation. Dr. Wheeler determined that the Claimant had small, category 0/1 opacities and either no large opacities consistent with pneumoconiosis or large opacities that qualified as category A pneumoconiosis. As a result, while the November 6, 1998, x-ray study does not support a finding of simple pneumoconiosis, it is not inconsistent with a finding of complicated pneumoconiosis.

An x-ray study taken April 19, 2000, was interpreted by four physicians. Dr. Vosskuhler's interpretation is of little probative value because his qualifications are unknown and the interpretation does not address the presence or absence of pneumoconiosis. Dr. James, a B-Reader, determined that the Claimant had category 1 simple pneumoconiosis and category A opacities consistent with complicated pneumoconiosis. Dr. Repsher, also a B-Reader, determined that the x-ray exhibited no abnormalities consistent with pneumoconiosis. Dr. Wheeler, who is dually-qualified, continued to diagnose category 0/1 simple pneumoconiosis but diagnosed the Claimant with category 0 or A complicated pneumoconiosis (this time stating that the large opacities were "compatible . . . possibly with coal workers' pneumoconiosis"). Again, Dr. Wheeler finds category 0/1 simple pneumoconiosis but his large opacity observations are not

inconsistent with a diagnosis of complicated pneumoconiosis. These interpretations outweigh the negative interpretation of Dr. Repsher and, as a result, support a finding of simple and complicated pneumoconiosis.

Five physicians interpreted the November 30, 2000, x-ray of the Claimant's lungs. Dr. James and the dually-qualified Drs. Preger and Miller determined that the Claimant has simple pneumoconiosis as well as category A or B opacities consistent with complicated pneumoconiosis. Drs. Renn and Repsher, both B-Readers, determined that the x-ray study exhibited no abnormalities consistent with pneumoconiosis. The positive interpretations by two dually-qualified physicians and one B-Reader outweigh the two negative interpretations by B-Readers. As a result, the November 30, 2000, x-ray study supports the conclusion that the Claimant suffers from both simple and complicated pneumoconiosis.

There are two interpretations of each chest x-ray dated May 21, August 2, and August 13, 2001, as well as March 23, 2002. Dr. Rizzi's interpretation of the May 21, 2001, x-ray, Dr. Venkatappan's interpretation of the August 2, 2001, x-ray, Dr. Cordivin's interpretation of the August 13, 2001, x-ray, and Dr. Mazat's interpretation of the March 23, 2002, x-ray study are of little probative value because their qualifications are unknown and their reports do not address the presence or absence of pneumoconiosis. Dr. Wheeler interpreted all four of the x-ray studies and his reports are not inconsistent with a finding of complicated pneumoconiosis because he was once again unsure whether the Claimant had no large opacities consistent with pneumoconiosis, or had category A opacities consistent with pneumoconiosis. As a result, the four x-ray studies dating from May 21, 2001, to March 23, 2002, are not inconsistent with a finding of complicated pneumoconiosis.

The April 15, 2002, x-ray study of the Claimant's lungs was interpreted by Dr. Wheeler who, again, determined that the Claimant may have category 0/1 simple pneumoconiosis and category A large opacities consistent with complicated pneumoconiosis. Dr. Wheeler noted that his diagnosis "depends on [coal dust] exposure." As a result, the x-ray study is not inconsistent with a diagnosis of complicated pneumoconiosis.

The August 2, 2002, x-ray study was interpreted by three physicians. Dr. Clark's qualifications are unknown and, as a result, his interpretation is of little probative value. Dr. Lawrence Repsher, a B-Reader, determined that there were no abnormalities consistent with pneumoconiosis. The dually-qualified Dr. Wheeler determined the Claimant may have category A large opacities consistent with pneumoconiosis, but that the diagnosis depends on the Claimant's exposure to coal dust. Dr. Wheeler's interpretation is not inconsistent with a finding of complicated pneumoconiosis and it outweighs Dr. Repsher's negative interpretation because of Dr. Wheeler's superior radiological qualifications.

The February 6 and February 9, 2005, x-ray studies were each interpreted once by Dr. Repsher. Dr. Repsher determined that there were no parenchymal or pleural abnormalities consistent with pneumoconiosis. Consequently, neither x-ray study supports a diagnosis of coal workers' pneumoconiosis. Notably, although these studies are the most recent of record, they are not the most probative. Dr. Repsher has consistently interpreted studies over time as revealing no parenchymal or pleural abnormalities consistent with pneumoconiosis. His

interpretations have been outweighed by the observations of other B-Readers and dually-qualified physicians. As a result, Dr. Repsher's interpretations of the 2005 studies do not persuade this tribunal that the disease, in its simple and complicated forms, is not present. This is particularly so in light of the temporal proximity of the series of studies pre-dating the February, 2005, studies.

On balance, the studies reveal opacities and masses that support diagnoses of complicated pneumoconiosis. Drs. James and Coultas, who are both B-Readers, and the dually-qualified Drs. Preger and Miller definitively diagnosed the presence of complicated pneumoconiosis. Dr. Wheeler's interpretations of various studies are not inconsistent with these findings because he found it was "possible" that the Claimant suffers from complicated pneumoconiosis with category A opacities. Each of these physicians also made additional diagnoses of other abnormalities on the Claimant's x-rays. These interpretations diagnosing the Claimant with complicated pneumoconiosis outweigh contrary x-ray interpretations by Drs. Repsher, Cole and Renn.

B. Biopsy Evidence

In addition to chest x-ray interpretations, a biopsy conducted and reported in compliance with 20 C.F.R. § 718.106 may constitute a basis for a finding of the presence of pneumoconiosis. 20 C.F.R. § 718.202(a)(2). As no biopsy evidence is in the record, this section is inapplicable to this claim.

C. Operation of Presumption

In addition to chest x-rays and biopsies, the existence of pneumoconiosis can be established by the operation of a presumption. Under 20 C.F.R. § 718.304 (2005), there is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if he suffers from complicated pneumoconiosis. In *Looney v. Shady Lane Coal Corp.*, BRB No. 06-0508 BLA (Feb. 28, 2007)(unpub.), a case arising in the Fourth Circuit, the Board held the following:

> In determining whether claimant has established invocation of the irrebuttable presumption of total disability due to pneumoconiosis pursuant to Section 718.304, the administrative law judge must weigh together all of the evidence relevant to the presence or absence of complicated pneumoconiosis, including evidence of simple pneumoconiosis and of no pneumoconiosis.

Complicated pneumoconiosis is established by x-rays yielding one or more large opacities (greater than one centimeter in diameter); by biopsy evidence yielding massive lesions in the lung; or by an equivalent diagnosis result reached by other means. 20 C.F.R. § 718.304(a)-(c). The determination of whether the miner has complicated pneumoconiosis is a finding of fact, and the administrative law judge must consider and weigh all relevant evidence. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985).

The available x-ray evidence, which is discussed above, establishes that the Claimant suffers from complicated pneumoconiosis. There is no biopsy evidence available for evaluation; thus, only the third, "other means" category remains to establish that the Claimant has complicated pneumoconiosis. This category includes CT-scans, of which there are twelve in the record. Twenty C.F.R. § 718.107 allows CT-scans to be submitted in connection with a claim and instructs that the "party submitting the test or procedure pursuant to this section bears the burden to demonstrate that the test or procedure is medically acceptable and relevant to establishing or refuting a claimant's entitlement to benefits." 20 C.F.R. § 718.107(b) (2005). The following CT-scan reports are in the record:

Ex. #	***Physician/ Qualifications***	***Date of CT-Scan***	***Date of Report***	***Comments***
DX 24	Lawrence Repsher/ B-Reader	Unknown	6/12/01	- In a narrative report as part of a medical opinion - *Observations:* extensive calcification of the mediastinal and hilar lymph nodes, again confirming underlying healed tuberculosis
EX 27	John Rizzi/ Qualifications Unknown	5/21/01 – Two Views of Chest	5/22/01	- Comparison to 1998 chest x-ray - *View I Findings:* Extensive interstitial disease which appears to predominate within the upper lobes bilaterally; only slightly increased compared to 1998 x-ray. - *View II Findings:* Significant amount of interstitial lung disease; architectural distortion . . . with associated nodular masses bilaterally; no pulmonary nodules; scattered calcifications . . . consistent with old granulomatous disease.
EX 29	Paul S. Wheeler/ Board-Certified Radiologist, B-Reader	5/21/01	2/6/06	- *Observations:* Oval 3 cm mass lateral subapical lul, 2 cm mass superior segment lll, and 3 cm mass lower posterior rul involving upper right hilum compatible with conglomerate granulomatous disease, TB or histoplasmosis, more likely than large opacities of coal workers' pneumoconiosis because small background nodular infiltrates in upper lobes are very low profusion; minimal emphysema; scars in periphery lungs from healed inflammatory disease; calcified granulomata . . . compatible with healed histoplasmosis - *Other Comments:* Coal workers' pneumoconiosis is possible because of the Claimant's age but lung disease is most likely conglomerate granulomatous disease . . . High unprotected dust exposure is required for large opacities of coal workers' pneumoconiosis
EX 7	Leslie N. Nishimi/ Qualifications Unknown	8/2/01 – Abdomen and pelvis	8/3/01	- *Observations:* mild pleural thickening posteriorly without definite pleural effusion; mild bibasilar subsegmental atelectasis or scaring
EX 7	Leslie N. Nishimi/ Qualifications Unknown	8/2/01 – Cervical Spine	8/3/01	- *Observations:* Ill-defined noncalcified pulmonary nodule in the left upper lobe posterolaterally measuring at least 1 cm in diameter with linear stranding towards the pleura which is focally

				thickened; nonspecific 4 mm pleural based nodule - *Impression:* Incompletely evaluated. Correlation with CT chest without and with IV contrast is suggested
EX 8 at 208	Edgar Cordivin/ Qualifications Unknown	8/15/01 – Thorax	Unknown	- *Observations:* conglomerate infiltrates in the perihilar areas bilaterally; interstitial lung disease - *Impression:* Findings consistent with silicosis. Recommend comparison with previous chest x-rays as lung carcinoma cannot totally be ruled out
EX 36	Lawrence Repsher/ B-Reader	8/15/01	2/22/06	- In a narrative report as part of a medical opinion - *Observations:* Classic bilateral upper lobe conglomerate tuberculosis; no biapical rounded opacities that would suggest coal workers' pneumoconiosis
EX 36	Lawrence Repsher/ B-Reader	2/1/05	2/22/06	- In a narrative report as part of medical opinion - *Observations:* marked progression, particularly in the right upper zone, suggesting reactivated tuberculosis
CX 7	Gorman/ Qualifications Unknown	9/16/05 – Chest	9/21/05	- *Observations:* diffuse interstitial fibrosis in the right upper lobe, with significant pleural thickening; 3 cm mass type lesions in the mid upper lobes bilaterally and fibrotic stranding; secondary malignancy cannot be excluded; small calcified hilar nodes - *Impression:* Severe post inflammatory changes bilaterally, cannot rule out malignancy
CX 6	Gorman/ Qualifications Unknown	10/7/05 – Chest	10/17/05	- Compared to 9/16/05 CT-scan, appearance is unchanged - *Observations:* scarring in the right upper lobes with thick interstitial disease, volume loss, and bronchiectasis; calcifications . . . probably due to prior granulomatous disease; spiculated nodules . . . in a background of interstitial fibrosis; active small airway disease - Focally active infectious disease or superimposed lung cancer remain a possibility - *Conclusion:* Extensive parenchymal disease in both lungs . . . most of the disease appears to be due to fibrosis . . . suggest active small airway infection . . . two spiculated masses in the left lung
CX 10	Edgar Cordivin/ Qualifications Unknown	2/28/06 – Abdominal Series	Unknown	- *Observations:* extensive scarring in both upper lobes consistent with old granulomatous disease . . . suggestion of a right pleural effusion and possible right lower lobe infiltrate - *Impression:* Extensive pulmonary scarring, no acute abnormality identified
CX 10	Edgar Cordivin/ Qualifications Unknown	2/28/06 – Chest	Unknown	- *Comments:* a couple of lung nodules in the upper lobe measuring approximately 3 cm in size; no mediastinal or hilar lymphadenopathy; pleural effusion; doubt malignancy

Six physicians interpreted twelve CT-scans taken between May, 2001, and February,

2006. Eight out of the twelve interpretations were by physicians whose qualifications are unknown. As with the chest x-ray evidence, interpretations by physicians whose qualifications are unknown are of little probative value. Specifically, the conclusions of Drs. Rizzi, Nishimi, Cordivin, and Gorman are not persuasive of the presence or absence of complicated pneumoconiosis as their qualifications are unknown.

Dr. Repsher, a B-Reader, provided brief narratives about three CT-scans as a part of his medical opinions, concluding that the masses in the Claimant's lungs represent tuberculosis and not pneumoconiosis. His opinion and those of the physicians whose qualifications are unknown are outweighed by that of Dr. Wheeler, a dually-qualified physician. Dr. Wheeler reviewed the May, 2001, CT-scan and found two 3-centimeter and one 2-centimeter masses in the Claimant's lungs. This is consistent with his x-ray findings of possible category A pneumoconiosis. Although Dr. Wheeler is uncertain of the etiology of the masses, he acknowledges the "possible" presence of coal workers' pneumoconiosis among other potential diagnoses. Dr. Wheeler's interpretation of the May 21, 2001, CT-scan is more probative than the rest of the CT-scan reports because he is a dually-qualified physician. As a result, the weight of the CT-scan evidence supports the conclusion that the Claimant suffers from complicated pneumoconiosis.

In conclusion, the x-ray and CT-scan evidence show significant abnormalities in the Claimant's lungs that qualify as complicated pneumoconiosis. As a result, the Claimant is entitled to the irrebuttable presumption under 20 C.F.R. § 718.304 that he is totally disabled due to pneumoconiosis. The remaining issue is whether the Claimant's complicated pneumoconiosis arose out of coal mine employment.

D. Etiology of the Miner's Complicated Pneumoconiosis

Under 20 C.F.R. §718.203(a), once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. If a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b) (2005). The ten year presumption cannot be used as a bootstrap to prove the existence of pneumoconiosis. A miner with ten years of coal mine employment is not presumed to have pneumoconiosis; rather, he must establish the existence of pneumoconiosis by a preponderance of the evidence. Once the existence of pneumoconiosis is established, however, the causal connection between the pneumoconiosis and the coal mine employment is presumed if the miner has ten years of coal mine employment or more.

In this case, the Claimant is entitled to the presumption because he has established that he suffers from complicated pneumoconiosis and that he worked in the Employer's mines for over ten years. The Claimant's testimony and the Employer's records indicate that the Claimant worked in the Employer's mines as a Tipple Attendant from October, 1973, to January, 1995**.** Consistent with the recent Fourth Circuit decision in *The Daniels Co. v. Director, OWCP [Mitchell]*, 479 F.3d 321, 334 (4th Cir. 2007), the Claimant is entitled to a rebuttable presumption that his complicated pneumoconiosis arose out of coal dust exposure. In rebuttal, the Employer

offers the Claimant's history of tuberculosis as the cause of the abnormalities in the Claimant's lungs.

The Claimant's pulmonary history is somewhat murky because of his history of tuberculosis, as indicated by at least one positive tuberculin skin test (PPD) and treatment for the disease in 2000. *EX 8 at 32 and 294.* The CT-scan reports and medical opinions clearly struggle with this history in determining the cause of the opacities in the Claimant's lungs. It is important to note, however, that "[a] diagnosis of tuberculosis does not necessarily exclude the possibility that a miner also suffers from pneumoconiosis." *Yogi Mining Co. v. Director, OWCP [Fife]*, Case No. 04-2140 (4th Cir., Dec. 7, 2005)(unpub.).

Several physicians provided medical opinions concerning the opacities and some suggested alternative or additional explanations for the possible cause of the large masses in the Claimant's lungs. The medical opinions are as follows:

1. Dr. F. Mosely examined the Claimant on July 8, 1997, after the Claimant filed his first claim for benefits under the Act. *DX 29.* He recorded the Claimant's coal mining and medical history, noting that the Claimant did not have a history of tuberculosis. *Id.* After a physical examination, Dr. Mosely did not diagnose the Claimant with pneumoconiosis, merely noting that the Claimant has arthritis. *Id.*

2. Dr. Lawrence Repsher, a B-Reader, examined the Claimant on January 19, 1998, and wrote his first medical opinion on February 6, 1998. *DX 29.* After review of the Claimant's January 19, 1998, x-ray, and other medical data, Dr. Repsher determined that there is no evidence of pneumoconiosis and that the Claimant has pulmonary tuberculosis of unclear activity. *Id.*

   Dr. Repsher provided a second medical opinion on June 12, 2001, after examining the Claimant on May 21, 2001. *DX 24.* Dr. Repsher reviewed two chest x-rays that were not available when he previously examined the Claimant – the June 17, 1997, and November 30, 2000, studies. *Id.* It appears that Dr. Repsher did not have access to the November 6, 1998, April 19, 2000, or May 21, 2001, x-rays at the time of this report. *Id.* Dr. Repsher determined that the x-rays "continue to show the changes of healed tuberculosis," as "confirmed by a noncontrast CT-scan showing extensive calcification of the mediastinal and hilar lymph nodes." *Id.* Dr. Repsher determined that there is no evidence of coal workers' pneumoconiosis and diagnosed the Claimant with "[p]ulmonary tuberculosis, probably inactive." *Id.* Dr. Repsher concluded that the Claimant "has no chest x-ray evidence of coal workers' pneumoconiosis." *Id.*

   Dr. Repsher provided a supplement to his opinions on April 29, 2004. *EX 18.* He considered five additional x-ray interpretations that had been previously unavailable. *Id.* Dr. Repsher concluded that there is "[n]o definite evidence of [coal workers' pneumoconiosis]. However, I cannot rule out histologic [coal workers' pneumoconiosis]." *Id.* In addition to possible pneumoconiosis, Dr. Repsher concluded that the Claimant has inactive healed tuberculosis. *Id.* Dr. Repsher

explained "[t]o an overwhelming probability, the bilateral and pulmonary scars are the result of tuberculosis and not pneumoconiosis . . . [h]owever, even if one were to concede the presence of pneumoconiosis, it would be overwhelmingly most likely due to his prior 12 year history of underground uranium mining" because of a lack of dust controls at that time. *Id.* Dr. Repsher concluded that the Claimant "may have mild simple superimposed coal workers' pneumoconiosis" but does not have any impairment. *Id.*

Dr. Repsher provided a second supplemental opinion on May 6, 2004, after receiving several additional x-rays dating from October 6, 1993, to August 2, 2002. *EX 23.* It is unclear which x-ray interpretations Dr. Repsher received, but he concluded that "[n]one of these x-rays show any evidence of pneumoconiosis" and that "all of the findings are overwhelmingly most likely due to healed tuberculosis." *Id.* Dr. Repsher reasoned that the Claimant's x-rays had not change in nine years, the appearance is "classically characteristic of healed tuberculosis . . . seen many times in older Navajo Indians," the "conglomerate lesions involve the pleura, which never occurs with complicated pneumoconiosis," and there is "no background of small opacities." *Id.* Dr. Repsher also noted the Claimant had a positive PPD test, subsequent treatment for tuberculosis, and a May 21, 2001, CT scan which "shows characteristic findings of healed tuberculosis." *Id.*

Dr. Repsher provided a third supplemental medical opinion on February 22, 2006, after reviewing the February 6 and 9, 2005, x-ray studies and the August 15, 2001, and February 1, 2005, CT-scans. *EX 36.* Dr. Repsher noted that there was a marked progression between the two CT-scans and concluded that the "very impressive radiographic findings have been and continue to be due to far advanced pulmonary tuberculosis." *Id.*

Dr. Repsher also testified at the hearing on March 14, 2006. *Tr. 37-77.* He testified that the Claimant's "horrible chest x-ray is characterized by large conglomerate masses in both upper lobes, right much greater than left, associated with heavy calcification in the center of chest and in the lymph nodes at the root of the lungs on either side, both the right and the left lungs." *Tr. 43.* Dr. Repsher noted that the Claimant had at least two positive PPD tests and has been treated in 2000 and 2004. *Id.* Dr. Repsher stated that the Claimant's x-ray "has been stable, probably since the late '70s or early '80s, which would be characteristic of healed [tuberculosis]. It was stable until the last year or so and the conglomerate masses have enlarged, which would make one worry about re-activation of [tuberculosis]." *Tr. 43-44.* Dr. Repsher went on to say that the masses on the x-rays are spiculated and represent conglomerate tuberculosis. *Tr. 46.* Dr. Repsher then stated that the Claimant's lungs do not have a background of small opacities with the large masses and the masses involve the pleura, which means the large masses represent tuberculosis or granulomatous disease rather than pneumoconiosis. *Tr. 49 & 53.* Dr. Repsher also expressed concern that the Claimant is at a very high risk of lung cancer because of his work in the uranium mines and noted that he had once recommended that the Claimant be evaluated for lung cancer. *Tr. 44.*

3. Dr. David James provided a medical opinion on February 19, 2001, after having examined the Claimant on November 30, 2000. *DX 6.* Dr. James considered x-rays dating from 1962 through 1995 from the Kayenta Clinic, as well as the x-ray studies taken on November 30, 2000. *Id.* Dr. James noted that the Claimant had a positive PPD test along with negative sputum cultures in April 2000, and subsequently underwent four months of INH and Rifampiz treatment. *Id.* Dr. James determined that the Claimant has complicated pneumoconiosis and that his work as a coal miner was a "significant contributing factor." *Id.* In addition to coal workers' pneumoconiosis, Dr. James determined that "[m]ore likely than not, [the Claimant] also has silicosis" due to silica dust exposure as a uranium and copper miner and because of his history of abnormal chest x-rays prior to his work as a coal miner. *Id.*

4. Dr. Peter Tuteur provided an independent medical evaluation on August 15, 2001. *EX 1.* Dr. Tuteur did not examine the Claimant but reviewed eighteen chest x-ray reports concerning fourteen studies through May 21, 2001; and the May 21, 2001, CT-scan report by Dr. Rizzi. *Id.* It is notable that Dr. Tuteur did not have access to eighteen of the interpretations of the x-rays taken between October 16, 1993, and May 21, 2001, which are listed above in the *Chest X-Ray Evidence* portion of the opinion. Dr. Tuteur noted that the Claimant had a negative 1995 PPD, negative sputum, and a positive 2000 PPD, resulting in a four month treatment program for tuberculosis. *Id.* Dr. Tuteur determined that the x-ray abnormalities were consistent with coal workers' pneumoconiosis, silicosis, as well as infectious granulomatous diseases such as tuberculosis, and possibly systemic non-infectious diseases such as sarcoidosis. *Id.* Dr. Tuteur also noted "[c]learly, [the Claimant] was exposed to sufficient amounts of coal mine dust to produce coal workers' pneumoconiosis in a susceptible host." *Id.* He stated that "even if one were to assume that the radiographic changes are a reflection of coal workers' pneumoconiosis, it would be of insufficient severity and profusion to produce clinical symptoms, physical examination abnormalities, or physiologic impairment." *Id.*

   Dr. Tuteur provided a supplemental independent medical review on March 15, 2004. He reviewed a total of thirty-eight x-ray interpretations prepared by eighteen physicians concerning twenty-one x-ray studies through August 2, 2002. *EX 13.* It is notable that Dr. Tuteur did not have eighteen of the interpretations that are listed above in the *Chest X-Ray Evidence* portion of the opinion and he also reviewed six additional interpretations that are not in the record. *Id.* Additionally, Dr. Tuteur failed to note that Dr. James observed large opacities consistent with pneumoconiosis in the October 6, 1993, and April 27, 1995, x-ray studies, and that Dr. Coultas observed both small and large opacities consistent with pneumoconiosis on the October 6, 1993, study. *Id.* Dr. Tuteur noted that the Claimant had a positive PPD as early as 1981 and stated that "[r]egularly, though unfortunately intermittent, treating physicians have linked the positive PPD to the abnormalities on the chest x-ray." *Id.* Dr. Tuteur also noted negative sputum tests for tuberculosis in 1995 and 2000. *Id.* He stated

> [i]t is in my opinion that based on the radiographic data as well as the available historic data, it is not possible to determine whether the radiographic changes are due to an infectious granulomatous disease such as tuberculosis and/or the chronic inhalation of coal mine dust yielding simple coal workers' pneumoconiosis.

Id. He went further to say that the Claimant "absolutely has tuberculosis infection causing upper lung field infiltrative process . . . [y]et, since the radiographs are abnormal also in a fashion consistent with coal workers' pneumoconiosis, the superimposition of very mild simple coal workers' pneumoconiosis cannot be excluded." *Id.* Dr. Tuteur did not address the various x-ray interpretations that describe large opacities consistent with pneumoconiosis.

Dr. Tuteur testified by deposition on May 10, 2004. *EX 26.* He stated that the Claimant "clearly was exposed to sufficient amounts of coal mine dust to produce coal workers' pneumoconiosis in a susceptible host." He went on to say that

> [s]ince [the Claimant] has an abnormal chest radiograph, and that abnormality from the infectious granulomatous disease involves the upper lung fields, the site where coal workers' pneumoconiosis most frequently is demonstrated, it is impossible to say that there is absolutely none of the radiographic changes that are present that could be due to coal workers' pneumoconiosis."

EX 26 at 18. Dr. Tuteur explained that "even if one assumes that there are some minor radiographic changes compatible with coal workers' pneumoconiosis, and that they are due to coal workers' pneumoconiosis, they would be of insufficient severity and profusion to produce clinical symptoms, physical examination abnormalities or impairment of pulmonary function." *EX 26 at 32.*

5. Dr. Joseph Renn performed an independent medical review on August 30, 2001. *EX 2.* He reviewed the Claimant's medical history but did not examine the Claimant. Dr. Renn had access to nine of the Claimant's x-ray interpretations from studies between April 27, 1995, to November 30, 2000. *Id.* One of the available interpretations was unreadable, four had been interpreted as positive for simple and complicated pneumoconiosis, and three were negative for pneumoconiosis. *Id.* He did not have access to twelve of the x-ray interpretations listed in the above *Chest X-Ray Evidence* section for the studies dating from April 27, 1995, to November 30, 2000. Dr. Renn noted that the Claimant had a positive PPD and negative sputum cultures in April, 2000, and was treated for tuberculosis for several months. *Id.* Dr. Renn concluded that the Claimant has "the residual of pulmonary tuberculosis" and asthma and went further to say that "none of the . . . diagnoses were either caused, or contributed to, by [sic] his exposure to coal mine dust." *Id.*

Dr. Renn testified by deposition on May 13, 2004. *EX 28.* He stated that he determined that the June 17, 1997, x-ray had changes consistent with old pulmonary

tuberculosis and found no changes consistent with pneumoconiosis. *EX 28 at 28.* He explained that tuberculosis "can mimic a lot of diseases" and can appear as large masses on an x-ray film. *Id.* Dr. Renn also noted that a partially to completely calcified density is indicative of tuberculosis. *EX 28 at 29.*

Dr. Renn testified during a second deposition on June 7, 2006. *EX 37.* He explained that the opacities observed on the June 17, 1997, and November 30, 2000, x-rays were consistent with tuberculosis because of the variability in the size and lack of uniformity in the profusion of the opacities, and the presence of calcification. *EX 37 at 36.* Dr. Renn stated that there had not been a radiographic change of condition in the Claimant's lungs between 1997 and 2000. *EX 37 at 42.*

6. Dr. James Castle provided an independent medical review on May 28, 2002. *EX 5.* Dr. Castle reviewed the Claimant's medical records and history but did not examine him or interpret x-ray studies. Dr. Castle based his opinion partially on the other medical opinions; one CT scan; and eleven x-ray interpretations of six studies dating from April 27, 1995, to May 21, 2001. *Id.* It is notable that, of the six x-ray studies, Dr. Castle did not have eleven of the interpretations listed above in the *Chest X-Ray Evidence* section and has two interpretations of the June 17, 1997, x-ray that are not in the record. *Id.* Dr. Castle noted that the x-ray interpretations showed a difference of opinions but determined that the Claimant "most likely does have evidence of coal workers' pneumoconiosis radiographically" and that "[i]t is also clear that he does have evidence of granulomatous disease, namely tuberculosis," healed. *Id.* Dr. Castle then stated "[i]t is not possible to accurately determine the full extent of either of these processes and the impact that they have had on the chest x-ray." *Id.*

   Dr. Castle provided a supplemental report on April 19, 2004, after having reviewed additional medical data including x-ray interpretations, medical records, and medical opinions. *EX 15.* Dr. Castle concluded that the Claimant "possibly has both radiographic changes of chronic granulomatous disease, i.e. healed tuberculosis, as well as possible coal workers' pneumoconiosis" and that "it remains impossible to distinguish whether or not he has one or the other, but very likely has both." *Id.* Dr. Castle went on to state that it was his belief that the Claimant is not permanently and totally disabled as a result of either process. *Id.*

   Dr. Castle then testified by deposition on April 19, 2004. *EX 17.* He reiterated that he found radiographic changes consistent with both coal workers' pneumoconiosis and healed tuberculosis. *EX 17 at 10.*

7. Dr. Charles R. Braun examined the Claimant and provided his medical opinion on November 15, 2005. *CX 8.* Dr. Braun noted a 2005 x-ray where masses were observed, as well as two CT scans since 2005 which showed "extensive upper lobe parenchymal disease as well as two spiculated masses in the left lung," but did not provide his own interpretation. *Id.* Dr. Braun noted that the Claimant had a positive PPD and received subsequent treatment in the late 1990's. *Id.* Dr. Braun noted that the Claimant has "[a]pparent spiculated masses" and diagnosed him with "[p]robable

interstitial disease, secondary to uranium and coal mining." *Id.* Dr. Braun also expressed concern that there might be "atypical infections" and possibly malignancy. *Id.*

The weight of the medical opinions concerning the cause of the masses on the Claimant's lungs supports the conclusion that Claimant's pneumoconiosis arose out of coal mine employment. In *Looney*, the Board held that "the relevant question," in weighing physicians' opinions regarding the existence of complicated pneumoconiosis "is not whether [the physicians] definitively found the changes in claimant's lungs to be due to other diseases, but whether these physicians definitively excluded complicated pneumoconiosis as a diagnosis. (citation omitted)." *Slip op.* at 10. The opinions by the seven physicians do not definitively exclude complicated coal workers' pneumoconiosis as a diagnosis. Dr. Mosely's opinion is unhelpful because it does not address the abnormalities visible on the Claimant's x-ray studies taken during that time and makes no relevant diagnosis. Of the six remaining physicians, none conclusively rule out complicated coal workers' pneumoconiosis and only one determined that the masses do not represent pneumoconiosis.

Dr. Lawrence Repsher's medical opinions about the etiology of the opacities visible on the x-ray studies contradict themselves and, as a result, are of little probative value. It is proper to accord little probative value to a physician's opinion which is inconsistent with his or her earlier report or testimony. *Hopton v. U.S. Steel Corp.*, 7 B.L.R. 1-12 (1984) (a failure to explain inconsistencies between two reports which were eight months apart rendered the physician's conclusions of little probative value); *Surma v. Rochester & Pittsburgh Coal Co.*, 6 B.L.R. 1-799 (1984) (physician's report discredited where he found total disability in a earlier report and then, without explanation, found no total disability in a report issued five years later). *See also Brazzale v. Director, OWCP*, 803 F.2d 934 (8th Cir. 1986) (a physician's opinion may be found unreasoned given inconsistencies in the physician's testimony and other conflicting opinions of record). In 2001, Dr. Repsher stated that there is no evidence of coal workers' pneumoconiosis. In April, 2004, he opined that the lung abnormalities are "to an overwhelming probability" due to tuberculosis, but if he were to concede that the abnormalities are due to pneumoconiosis, it is most likely related to the Claimant's uranium mining work. Dr. Repsher then went on to state that the Claimant "may have mild simple superimposed coal workers' pneumoconiosis." Seven days later and again in 2006, he reasoned that none of the Claimant's x-ray studies show evidence of coal workers' pneumoconiosis because there is not a background of small opacities. It is inexplicable how Dr. Repsher went from speculating that the abnormalities may have been caused by pneumoconiosis arising from either coal or uranium mining to determining that there is no evidence of pneumoconiosis on the Claimant's x-rays. Given his equivocal and inconsistent statements with regard to the x-ray evidence, Dr. Repsher's opinion regarding the etiology of the opacities is of little probative value.

Of the five remaining medical opinions concerning the masses in the Claimant's lungs, one physician determined that the masses were not coal workers' pneumoconiosis and the remainder determined that the Claimant has coal workers' pneumoconiosis along with some other disease process. Dr. Joseph Renn, a B-Reader, determined that the masses were consistent with tuberculosis because of the profusion, variability in size, and calcification present in the opacities. Dr. Renn's diagnosis of tuberculosis is outweighed by the x-ray interpretations of Drs.

James and Coultas, who are B-Readers, as well as the dually-qualified Drs. Preger and Miller. These physicians reasonably conclude that the large opacity noted on the x-rays represent pneumoconiosis.

Indeed, four physicians diagnose the Claimant with tuberculosis or another pulmonary disease *in addition to* coal workers' pneumoconiosis. Such diagnoses are more consistent with the objective medical evidence and, as a result, are more probative. Dr. Charles Braun reviewed a limited number of x-ray studies and CT-scans and diagnosed the Claimant with "probable interstitial disease" secondary to coal mining as well as possible infection or malignancy. Dr. David James, a B-Reader, provided a well-documented opinion and determined that the lung masses visible on the Claimant's x-ray studies were compatible with coal workers' pneumoconiosis as well as silicosis secondary to uranium mining. Dr. James specifically noted the Claimant's significant work history as a coal miner when making this diagnosis.

Dr. Tuteur opined that it was impossible to determine whether the Claimant's x-ray evidence represented coal workers' pneumoconiosis, infectious granulomatous disease, or systemic non-infectious disease such as sarcoidosis. Although he opined that the Claimant had simple and not complicated pneumoconiosis, he did so without properly accounting for three interpretations by B-Readers who observed category A and B opacities consistent with pneumoconiosis. Dr. James Castle also determined that it was impossible to distinguish whether the Claimant's radiographic changes were caused by a granulomatous disease such as tuberculosis or by coal workers' pneumoconiosis and stated that the Claimant very likely suffers from both diseases. Dr. Castle went on to say that abnormalities consistent with complicated pneumoconiosis could have calcification, which is also common with tuberculosis. The opinions of these physicians are insufficient to rebut the presumption at 20 C.F.R. § 718.203(b) of the regulations.

In conclusion, a preponderance of the medical opinions regarding the etiology of the Claimant's pneumoconiosis in conjunction with the presumption at 20 C. F.R. § 718.203(b) supports the conclusion that the opacities were caused by coal dust exposure. The Claimant's pulmonary history is complex and unclear, as noted by Drs. Castle, Tuteur, James, and Braun, who determined that the Claimant suffers from both coal workers' pneumoconiosis and some other disease. The objective medical evidence and the opinions of the aforementioned physicians support the conclusion that the Claimant has complicated pneumoconiosis arising out of coal mine employment because the evidence is insufficient to demonstrate that the large masses on the x-ray are due to some other disease process besides coal workers' pneumoconiosis. Therefore, the presumption that the miner's pneumoconiosis arose out of coal mine employment under 20 C.F.R. § 718.203(b) (2005) remains unrebutted.

ONSET OF BENEFITS

The Claimant is entitled to benefits commencing on the date the medical evidence first establishes that he became totally disabled due to pneumoconiosis or, if such a date cannot be determined from the record, the month in which the miner filed his claim which, in this case, is May, 1997. 20 C.F.R. § 725.503 (2005); *Carney v. Director, OWCP*, 11 B.L.R. 1-32 (1987);

Owens v. Jewell Smokeless Coal Corp., 14 B.L.R. 1-47 (1990). It is noteworthy that the date of the first medical evidence of record indicating total disability does not establish the onset date; rather, such evidence only indicates that the miner became totally disabled at some prior point in time. *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984); *Hall v. Consolidation Coal Co.*, 6 B.L.R. 1-1306, 1-1310 (1984).

The Claimant's first x-ray study that was interpreted as positive for complicated pneumoconiosis was taken on October 6, 1993. Dr. David James determined that there were category A opacities and Dr. Coultas determined that there were category B opacities consistent with pneumoconiosis. Generally, a miner is not entitled to benefits for any period during which he or she engaged in coal mine employment or comparable gainful work. 20 C.F.R. §725.504 (2001). However, if the miner has shown that he has complicated pneumoconiosis under 30 U.S.C. §921(c)(3), continued employment does not preclude the commencement of benefits. 20 C.F.R. §725.504(c) (2001). Here, the Claimant worked in the Employer's mines until January, 1995, but has proven that he suffers from complicated pneumoconiosis arising out of coal mine employment as early as October, 1993. As a result, it is determined that the Claimant's benefits are payable from October, 1993, the month in which the Claimant became totally disabled by pneumoconiosis. Accordingly,

ORDER

IT IS ORDERED that the claim for living miner benefits filed by the Claimant is granted and the payment of benefits shall commence as of October, 1993. IT IS FURTHER ORDERED that, within 30 days of the date of issuance of this Decision, Claimant's counsel shall file, with this Office and with opposing counsel, a petition for a representatives' fees and costs in accordance with the regulatory requirements set forth at 20 C.F.R. § 725.366 (2005). Counsel for the Director and for Employer shall file any objections with this Office and with Claimant's counsel within 20 days of receipt of the petition for fees and costs. It is requested that the petition for services and costs clearly provide (1) counsel's hourly rate with supporting argument or documentation, (2) a clear itemization of the complexity and type of services rendered, and (3) that the petition contains a request for payment for services rendered and costs incurred before this Office only as the undersigned does not have authority to adjudicate fee petitions for work performed before the district director or appellate tribunals. *Ilkewicz v. Director, OWCP*, 4 B.L.R. 1-400 (1982).

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John M. Vittone
Chief Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).